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#### DOCUMENT HISTORY

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	1.0	November 15, 2005	Initial version Uniform Managed Care Manual Chapter 2.0, "Uniform Managed Care Claims Manual."
Revision	1.1	September 1, 2006	Chapter 2.0 is modified to provide clarification resulting from the implementation of the Joint Medicaid/CHIP HMO Contract.
Revision	1.2	October 20, 2007	Chapter 2.0 is modified to clarify language regarding payment of Out-of-Network providers. Chapter title is changed from Claims Manual to Uniform Managed Care Claims Manual.
Revision	1.3	March 1, 2011	Chapter 2.0 is modified to clarify language regarding the "Ninety-five Day Provider Claim Filing Deadline." All Sections were numbered for ease of reference.
Revision	2.0	March 1, 2012	<p>Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, and 529-12-0002.</p> <p>Section VII, "Claims Processing and Reporting Classifications," is modified revise the definition of "Adjusted Claim" to include pharmacy claims.</p> <p>Section VIII, "Claims Processing Requirements," is modified to add language regarding reduction or denial of a payment for Provider Preventable Conditions and to add a subsection addressing provider-administered drugs.</p> <p>Section XII, "Ninety-five Day Provider Claims Filing Deadline," is modified to require that Medicaid MCOs comply with 42 C.F.R. 433.139.</p>



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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Revision	2.1	March 20, 2013	<p>Section III, "Statutory and Regulatory Authority" is modified to add reference to 42 C.F.R. § 433.139 and to standardize reference to the Texas Administrative Code.</p> <p>Section IV, "Informational Resources" is modified to standardize references to the Texas Administrative Code.</p> <p>Section V, "Background" is modified to correct grammatical errors and to change "it is expected that the MCOs will" to "MCOs must" in the first paragraph.</p> <p>Section VI, "Claims Definitions" is modified to remove the definitions for Adjudicate and Clean Claim as being duplicative of definitions in the contract.</p> <p>Section VII, "Claims Processing and Reporting Classifications" is modified to remove "but are not limited to" from "Examples of rejected claims include."</p> <p>Section VIII, "Claims Processing Requirements," is modified to clarify that MCOs cannot charge Members or providers claims adjudication fees. In addition, references to the Texas Medicaid Bulletin are removed.</p> <p>Section X, "Performance Requirements and Timeframes" is modified to correct grammatical errors.</p> <p>Section XII, "Ninety-five Day Provider Claim Filing Deadline" is modified to correct a TMPPM reference.</p> <p>Section XV, "Internal Claims Auditing" is modified to clarify that the claims auditing function should report to a higher "executive" management position and that claims data, processing, performance, and functions are subject to audit by federal as well as state audit entities.</p> <p>Section XVI, "Health Insurance Portability and Accountability Act (HIPAA) Compliance" is renamed "HIPAA in Remittance Formats" and some language is removed as being duplicative of the contract.</p> <p>Section XVIII, "System/Subcontractor Changes" is modified to change the notification for systems changes and termination of subcontractors from 90 days to 180 days.</p> <p>Section XIX, "Data Retention" is modified to clarify that whenever their claims system is upgraded or replaced, the MCOs must ensure that all historical claims data is still accessible.</p>



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Revision	2.2	September 15, 2013	Section VIII, "Claims Processing Requirements," is modified to require CHIP Institutional Claims and Encounter data to include POA indicators and to change "Provider Preventable Conditions" to "Potentially Preventable Complications."
Revision	2.3	November 1, 2014	



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			<p>Revision 2.3 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, and 529-13-042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.</p> <p>Section I, "Applicability of Chapter 2.0" is modified to include applicability to Medicare-Medicaid Plans (MMPs) and MCO subcontractors that perform claims processing functions.</p> <p>Section II, "Purpose" is modified to establish claims processing requirements for Nursing Facility Add-on Services and to clarify the meaning of "Days".</p> <p>Section V, "Background" is modified to include claims for Nursing Facility Add-on Services.</p> <p>Section VI, "Claims Definitions" is modified to add definition for Nursing Facility Add-on Services and to clarify that additional definitions can be found in this and other chapters of the UCM.</p> <p>Section VII, "Claims Processing and Reporting Classifications" is modified to clarify the definitions for Adjusted Claim, Rejected Claim, and Duplicate Claim.</p> <p>Section VIII. A, "Processing and Payment Requirements" is modified to change EOB to Remittance and Status Report or explanation of payment; to clarify the timeframe for submitting a request for additional information for Adjudication of a Deficient Claim; to clarify that only Adjudicated-Paid Claims can be adjusted; to clarify when the MCOs must withhold claims payment; to require Medicaid MCOs to be able to accept and process claims in compliance with the TMPPM; to include add a legal citation for coordination of benefits for secondary payors; and to change "Potentially Preventable Complications" back to "Provider Preventable Conditions" and to clarify that PPC includes any hospital-acquired conditions or healthcare acquired conditions identified in the TMPPM.</p> <p>Section VIII. C. "Claims System Requirements" is modified to clarify that that an Adjusted Claim must have a separate claims number from the previously Adjudicated-Paid claim.</p> <p>Section VIII. D. "Provider-administered Drugs" is modified to clarify that the MCO may deny or reject the entire claim or a claim line item for failing to comply with Clean Claim standards.</p> <p>Section VIII. E. "STAR+PLUS Services for Dual Eligibles" is added.</p> <p>Section VIII. F, "Nursing Facility Add-on Services" is added.</p> <p>Section VIII. G, "Nursing Facility Add-on Therapy Services" is added.</p>
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Revision	2.4	March 20, 2015	<p>Section VIII. A. "Processing and Payment Requirements," is modified to add requirements for Atypical Providers.</p> <p>Section VIII. D. is modified to change the name from "Provider-administered Drugs" to "Clinician-administered Drugs" and to clarify claims processing requirements for clinician-administered drugs not in an inpatient setting.</p> <p>Section VIII.E. "HCBS STAR+PLUS Waiver Services for Dual Eligibles" is modified to change the title to "STAR+PLUS Services for Dual Eligibles."</p>
Revision	2.5	February 25, 2016	<p>Revision 2.5 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-13-042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.</p> <p>Section I, "Applicability of Chapter 2.0" is modified to include applicability to the STAR Kids Program.</p> <p>Section VIII. E. "STAR+PLUS Services for Dual Eligibles" is renamed "STAR+PLUS and STAR Kids Services for Dual Eligibles" and the text is clarified.</p> <p>Section VIII. H. "Family Planning Services" is added.</p>
Revision	2.6	September 1, 2016	<p>Section VIII. D. "Clinician-administered Drugs" is modified to require use of the U8 modifier for 340B clinician-administered drug claims.</p>



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Revision	2.7	December 7, 2018	<p>Section VIII. A. "Processing and Payment Requirements," is modified to add a contract reference.</p> <p>Section VIII. D. "Clinician-administered Drugs" is clarifies billing and reimbursement language.</p> <p>Section VIII. E. "Clinician-administered Drugs Covered Under Non-Risk Payment" is added.</p> <p>Section VIII. I. "Human Donor Breast Milk" is added. Section X. "Performance Requirements and Timeframes" is modified to update the performance standards to match revisions made to claims summary reporting.</p> <p>Section XIX "Data Retention" is modified to comply with 42 CFR §438.3(h) and require the STAR+PLUS MCO portals to store up to 2 years of Nursing Facility claims payment data and all MCOs to store archival data that is easily retrievable for 10 years.</p> <p>Section XX. "Reporting Requirements" is modified to update the UMCM report section reference.</p>
Revision	2.8	June 25, 2019	<p>Section E – "Clinician-administered Drugs Covered Under Non-risk Payment" is updated to include a new drug, Crysvita.</p> <p>Crysvita is added to the list of clinician-administered drugs covered under a non-risk payment as: h) Crysvita effective November 1, 2018.</p>
Revision	2.9	January 1, 2021	<p>Section V. 3 "Received Date of Claim" updated to include claims processing requirements and timeframes for non-nursing facility claims forwarded to the MCO by the HHSC Administrative Service Contractor.</p> <p>Section VI. 11 "Claim Type" is updated to include dental.</p> <p>Section XIX "Reporting Requirements" is modified to update the UMCM chapter reporting reference.</p>



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Revision	2.10	July 1, 2021	Chapter 2.0 continues to apply to the Dental Services Contract. The new Dental Services Contract HHSC RFP number is HHS0002879.  Section VII. A., "Processing and Payment Requirements," is modified to remove Texas Insurance Code and federal (C.F.R.) language and replace with language that further clarifies that MCOs must obtain recovery of payment from a liable third party and not from a provider, unless the provider received payment from both the MCO and the liable third party. If the provider receives payment from both the MCO and a liable third party, the MCO must obtain recovery of the Medicaid or CHIP overpayment from the provider.
Revision	2.11	September 1, 2021	Section VII. D., "Clinician-administered Drugs," is modified to require compliance with UMCM 16.1.21 and UMCM 16.7.5.21.  Section VII. E., "Clinician-administered Drugs Covered Under Non-risk Payment," is modified to update source of non-risk drug

<sup>1</sup>Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions

<sup>2</sup>Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

<sup>3</sup>Brief description of the changes to the document made in the revision.



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## APPLICABILITY OF CHAPTER 2.0

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, including the Medicare-Medicaid Dual Demonstration, CHIP, STAR Kids, and STAR Health Programs, and Dental Contractors providing Texas Medicaid and CHIP Dental Services. In this chapter, references to “CHIP” or the “CHIP Managed Care Program(s)” apply to CHIP and the CHIP Dental Contractors. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs, and the Medicaid Dental Contractors. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Dental Contractors, Medicare-Medicaid Plans (MMPs) and any other entities licensed or approved by the Texas Department of Insurance. For purposes of this chapter, the term “MCO” also includes an MCO’s Subcontractor that performs claims processing functions.

The requirements in this chapter apply to all Programs, except where noted.

### I. PURPOSE

This chapter establishes the claims processing requirements and timelines that must be used by MCOs.

These requirements are based on the authorities noted below. The requirements apply to claims for all services covered under the MCOs’ managed care agreements (Contracts) with HHSC, including: (1) pharmacy Claims unless otherwise noted in UMCM Chapter 2.2, “Pharmacy Claims Manual,” and (2) Nursing Facility Claims unless otherwise noted in UMCM Chapter 2.3, “Nursing Facility Claims Manual.”

This chapter establishes the claims processing requirements for Nursing Facility Add-on Services. For the claims processing requirements for Nursing Facility Unit Rate services and Nursing Facility Medicare Coinsurance, refer to UMCM Chapter 2.3, “Nursing Facility Claims Manual.”

The term and spelling of “Provider” means contracted Network Providers, “provider” means all providers, Network and Out-of-Network, except when used to identify positions, headings, and index.

Unless otherwise stated, all required timeframes are based on “Days” as defined in Attachment A of the Contracts to mean calendar days.

### II. STATUTORY AND REGULATORY AUTHORITY

Statutory and regulatory authority for this chapter includes, without limitation:

- 42 U.S.C. § 1396a(a) (37) [§ 1902(a) (37) of the Social Security Act]
- 42 U.S.C. § 1396u-2(f) [§ 1932(f) of the Social Security Act]
- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191



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- 42 C.F.R. § 433.139
- 42 C.F.R. § 438.242
- 42 C.F.R. § 447.45
- 42 C.F.R. § 447.46
- 45 C.F.R. §§ 160 –164
- Texas Insurance Code § 843.349 (e) and (f)
- 1 Tex. Admin. Code § 353.4

### III. INFORMATIONAL RESOURCES

- 28 Tex. Admin. Code Chapter 20, Subchapter T, “Submission of Clean Claims”
- Texas Insurance Code Chapter 843, Subchapter J, “Payment of Claims to Physicians and Providers”
- 28 Tex. Admin. Code § 20.2826 waives the application of certain statutes and rules regarding prompt payment of claims as to Medicaid and CHIP managed care plans. HHSC has developed its own claims processing requirements that are informed by, but are not governed by, the Texas Department of Insurance requirements, unless noted in the statutory and regulatory authorities above.

### IV. BACKGROUND

MCOs that contract with HHSC are contracted on a “value based purchasing” basis. Under the “value based purchasing” approach, HHSC focuses on whether the MCOs processed the claims appropriately and timely. MCOs must deliver the services and meet the performance standards included in the Contracts between HHSC and the MCOs. This chapter provides the performance standards and filing requirements for appropriate and timely claims processing for Medicaid and CHIP claims, including claims for Acute Care, Behavioral Health, Vision, Long Term Services and Supports, and Nursing Facility Add-on Services.

The MCO must administer an effective, accurate, and efficient claims process in compliance with HHSC claim rules and regulations; applicable state and federal laws, rules, and regulations; the MCO’s Contracts with HHSC; and the Uniform Managed Care Manual.

### V. CLAIMS DEFINITIONS

**For the purposes of this chapter the following terms are defined:**

1. **Claims Processing:** The action(s) taken on a claim by the MCO or its subcontracted claims processor.
2. **Deficient Claim:** A claim submitted by a physician or provider for medical care or Health Care Services rendered to a Member that does not contain the data necessary for the MCO or its subcontracted claims processor to Adjudicate and accurately report and process the claim.



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3. **Received Date of Claim:** In accordance with 42 C.F.R. §§ 447.46(c) and 447.45(d)(5) (related to timely claims payments by MCOs):
  - a. The Received Date of Claim is the date that the claim was received by the MCO or its subcontracted claims processor, except for claims forwarded to the MCO from the HHSC Administrative Services Contractor; and
  - b. For claims forwarded to the MCO from the HHSC Administrative Services Contractor, the creation date of the claim, located in the ISAO9 field of the claim, is the Received Date of the Claim.
4. **Nursing Facility Add-on Services:** The types of services that are provided in a Nursing Facility setting by the Nursing Facility or other Network Provider but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services; physician-ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices.

Additional definitions are found in the MCO's Contracts, including Attachment A, and this and other Chapters of the Uniform Managed Care Manual.

## VI. CLAIMS PROCESSING AND REPORTING CLASSIFICATIONS

MCOs and their subcontracted claims processors are responsible for reporting the disposition of claims by the following HHSC classifications.

1. **Adjudicated-Paid Claim:** A Clean Claim for which a payment has been made to the provider.
2. **Adjudicated-Denied Claim:** A Clean Claim that has been denied for payment.
3. **Deficient-Denied Claim:** A claim denied for the purpose of obtaining additional information from the provider. A claim may be denied if it does not contain accurate and complete data in all claim fields that are required to Adjudicate as a Clean Claim.
4. **Deficient-Pended Claim:** A claim pended for the purpose of obtaining additional information from the provider. A claim may be pended if it does not contain accurate and complete data in all claim fields that are required to Adjudicate as a Clean Claim.
5. **Adjusted Claim:** A claim that has been previously Adjudicated as a Clean Claim by the MCO and has had a subsequent payment adjustment. Adjustments may not be made to a pharmacy claim. See the Pharmacy Claims Manual, Chapter 2.2, "Correction to Paid Claim."

Examples of Adjusted Claims include the following.

- a. If a primary explanation of benefits (EOB) is needed, the MCO may deny the original claim, request the EOB from the provider, and adjust the original claim with the EOB.
  - b. If a non-covered benefit is retrospectively approved to be a covered benefit, the MCO may deny the claim, and upon retrospective approval, the MCO may adjust the claim.
  - c. If HHSC retroactively changes rates, the MCO may adjust claims that were previously paid.
6. **Rejected Claim:** A claim:



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- a. filed with the MCO, or through an HHSC-designated portal, as applicable for services rendered to a patient who was not a Member of the MCO at the time the service was provided;
- b. that was filed with the MCO in error (wrong carrier); or
- c. for which the MCO is not responsible for processing; but the claim is for a Member of the MCO as of the date of service.

Examples of rejected claims include the following.

- The MCO Member was assigned to a risk group as of the date of service, and the HHSC claims administrator processes claims for such Members.
  - The services are paid directly by the HHSC claims administrator to the provider and not by the MCO as described in the Contracts. These services are not included in the Capitation Payment to the MCO.
7. **Other Unprocessed Claims:** A claim that has been received but has not yet been assigned a claim classification. This includes claims that are in a queue to be entered into the Claims Processing/Adjudication system.
  8. **Appealed Claim:** A claim that has been previously Adjudicated as a Clean Claim and the provider is appealing the disposition through written notification to the MCO and in accordance with the appeal process as defined in the MCO Provider Manual.
  9. **Duplicate Claim:** Any claim submitted by the provider that was included in a previously submitted claim by that provider for the same service provided to the same Member according to the maximum number of units of this service per day as set out in the Texas Medicaid Provider Procedure Manual. The term does not apply to Adjusted Claims, Appealed Claims, or claims submitted by a provider at the request of the MCO.
  10. **Capitated Service Claim:** A claim or claims report submitted by a Provider for rendered services for which the Provider has been prepaid (capitated) by the MCO. These claims are entered into the MCO claim system for data purposes only. No additional payment is made to the Provider.
  11. **Claim Type:** Facility or professional services for Acute Care, Behavioral Health, vision, long-term services and supports, dental, and Nursing Facility Add-on Services. Professional services are inclusive of services rendered by all providers. Within each Claim Type, claims data must be reported separately on the UB 04, CMS 1500, and 837 transactions, as applicable.

## VII. CLAIMS PROCESSING REQUIREMENTS

### A. Processing and Payment Requirements

Once a Clean Claim is received, the MCOs are required, within the 30-Day claim payment period, to:

- (1) pay the total amount of the claim, or part of the claim, in accordance with the Contracts,  
or



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- (2) deny the entire claim, or part of the claim, and notify the provider why the claim will not be paid.

Payment is considered paid on the date of:

- (1) the date of issue of a check for payment and its corresponding Remittance and Status (R&S) Report or explanation of payment to the provider by the MCO, or
- (2) electronic transmission, if payment is made electronically.

The MCO must submit a request for additional information necessary to allow Adjudication of a Deficient Claim from the provider within 30 Days from the date of the received date of claim. The MCO must Adjudicate Deficient-Pended or Deficient-Denied Claims for which additional information is requested within 30 Days from the date of receipt of the requested information.

The MCO must process to Adjudicated-Denied status any Deficient-Pended or Deficient-Denied Claims for which requested additional information is not received within 30 Days from the date the information was requested from the provider.

Once an initial claim has been Adjudicated to an Adjudicated-Paid or an Adjudicated-Denied status, MCOs will automatically adjust claims to reflect adjustments. For Claims that are in progress, the MCOs should complete Adjudication before processing any adjustments. MCOs can only adjust an Adjudicated claim. MCOs may not require providers to submit updated claims once a claim is an Adjudicated-Paid Claim.

MCO must make every effort to avoid making more than one request to the provider for additional information in connection with a specific claim.

MCO claim procedures must include processes intended to prevent a provider claim from being repeatedly Deficient-Denied for reasons that were present on the original claim submission.

Whenever possible, the MCO should identify each applicable reason code and specific information requirements to inform the provider of the precise data fields and issues related to each claim. At a minimum, MCO claim systems that employ a preset hierarchy of Deficient-Pended or Deficient-Denied reasons must provide sufficient information to the provider regarding the primary issue related to a claim.

The MCO must withhold all or part of payment for a claim submitted by a provider:

- (1) excluded or suspended from the Medicare, Medicaid, or CHIP Programs for Fraud, Waste, or Abuse;
- (2) on full or partial payment hold under the authority of HHSC or its authorized agent(s); or
- (3) with debts, settlements, pending payments, or accounts receivable due to HHSC, or the state or federal government.



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In addition to the requirements, a Medicaid MCO must process and pay Medicaid provider claims in accordance with the benefits limits and exclusions as listed in the Texas Medicaid Provider Procedures Manual (TMPPM).

The MCO may not directly or indirectly charge or hold a Member or a Network or out of network provider responsible for a fee for the adjudication of a claim.

MCOs must provide accurate and complete Encounter Data for all Covered Services, including Value-added Services. The Encounter Data must meet the requirements of the “**Encounter Data**” sections of the Contracts<sup>1</sup>, as well as, follow

- CHIP RSA Section 8.1.18.1
- Dental Section 8.1.12.1
- STAR Health Section 8.1.24.1
- STAR Kids Section 8.1.20.1
- STAR+PLUS Expansion Section 8.1.18.1
- STAR+PLUS MRSA Section 8.1.20.1
- UMCC Section 8.1.18.1

the format, rules, and data elements as described in the HIPAA-compliant 837 Professional Combined Implementation Guide or the 837 Institutional Combined Implementation Guide, and the 837 Professional Companion Guide or 837 Institutional Companion Guide. This information should be extracted from the MCO claim files for submission to HHSC.

MCO Claims Processing for both paper and electronic systems will comply with the requirements of the 837 transactions. This will produce consistent and verifiable data, whether self-reported by the MCO or produced by HHSC from the Encounter Data warehouse. The intent is to have uniform claims’ data that can and will be verified both at the claim and Financial Statistical Report level, with the control file being the Encounter Data File.

Atypical providers will submit appropriate documentation to the MCO. The MCO must obtain sufficient documentation for the atypical provider to accurately populate an 837 professional encounter. Please refer to the HIPAA-compliant 837 Professional Combined Implementation Guide and the 837 Professional Companion Guide for further information.

The MCO must obtain recovery of payment from a liable third party and not from the provider, unless the provider received payment from both the MCO and the liable third party. If the provider receives payment from both the MCO and a liable third party, the MCO must obtain recovery of the Medicaid or CHIP overpayment from the provider.

The MCO must notify the provider in writing that the provider has 120 Days from the date of disposition to appeal the claim. The MCO must process an Appealed Claim and Adjudicate the claim within 30 Days from the date of receipt of the Appeal. A provider may appeal any disposition of a claim.





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STAR, STAR+PLUS, STAR Kids, STAR Health, and CHIP institutional claims and Encounter Data must contain present on admission (POA) indicators, as required in the 837 Institutional Implementation and Companion Guides. MCOs are required to utilize the POA information submitted on claims to reduce or deny payment for Provider Preventable Conditions. If the MCO utilizes a per diem methodology for Adjudicating claims, the methodology must include a means for reduction or denial of payment for services related to a provider preventable condition that was not POA. This includes any hospital-acquired conditions or healthcare-acquired conditions identified in the TMPPM.

## **B. Other Required Claim Reporting Elements**

Capitated service claims will be reported as a separate line item on the claims summary report. Capitated service claims are prepaid and therefore not considered in the performance standards for claims payment. They cannot be included or reported in the fee-for-service data.

## **C. Claims System Requirements**

The MCO must maintain an automated Claims Processing system that registers the received date of claim, the detail of each claim transaction, or action, at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. This information must be at claim and line detail level, and maintained online and in archived files, as appropriate, per contractual record retention requirements. All claim data must be easily sorted and produced in formats as requested by HHSC. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

For an MCO to adjust an Adjudicated-Paid or Adjudicated-Denied claim, the Adjusted Claim must have a unique identifier not included on the previously adjudicated claim.

The MCO must offer its Providers and Subcontractors the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and Adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA- compliant electronic formats.

The MCO is responsible for its own claim system performance and reporting and that of its Subcontractors.

## **D. Clinician-administered Drugs**

With the exception of drugs administered in an inpatient setting, clinicians have the option of accessing some clinician-administered drugs as either medical benefits or pharmacy benefits based on their medical determination. If the clinician stocks the drug in the office and administers the drug, the clinician may submit a claim for the drug and the administration. However, if the drug is obtained from a pharmacy, the clinician may bill only for the administration of the drug.



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A Medicaid MCO may reimburse clinicians for dispensing a clinician-administered drug that is not on the Medicaid Vendor Drug Program (VDP) formulary if the drug is a covered Medicaid benefit, as defined in the TMPPM.

A CHIP MCO may reimburse a pharmacy or clinician for dispensing a clinician-administered drug that is on the CHIP VDP formulary.

Claims for pharmacy-dispensed, clinician-administered drugs must include a national drug code (NDC) number and must be transmitted to HHSC with the MCO's pharmacy Encounter Data in conjunction with the medical benefit of the administration of the drug.

All outpatient medical claims for clinician-administered drugs must contain a Healthcare Common Procedure Coding System (HCPCS) code, an NDC number, the NDC unit of measure, and the NDC quantity. The MCO must edit claims using

the Texas HHSC NDC to HCPCS Crosswalk file. The MCO must deny the entire claim or claim line item, if such a claim is missing the NDC information, or the

NDC is not valid for the corresponding HCPCS code, as the drug is not considered a covered Medicaid benefit. This requirement applies to Medicare cross-over claims in addition to the other claims where a third party paid a portion of the claim.

All eligible organizations and covered entities that are enrolled in the federal 340B Drug Pricing Program to purchase 340B discounted drugs must use modifier U8 when submitting claims for 340B clinician-administered drugs. MCOs are required to capture and include the U8 modifier on encounter extracts.

MCOs are required to comply with UMCM Chapter 16.1, "Medicaid and CHIP Contract Operational Guidance," specifically Section 16.1.21, "Pharmacy Services," and Section 16.7.5.21, "Drug Benefits."

## **E. Clinician-administered Drugs Covered Under Non-risk Payment**

An MCO is responsible for providing certain drugs on a non-risk, cost-settlement basis, in accordance with Section 10.18 "Non-Risk Payments for Drugs," Attachment A of the Contracts. Reimbursement by HHSC may be up to the Medicaid fee-for-service rate that HHSC would have paid for the drug on the date of service for a valid claim. The non-risk payments will cover only the cost of the drugs. HHSC selects reimbursement rates based on the lesser of the billed amount, a percentage of the Medicare rate, or one of the methodologies stated under 1 TAC § 355.8085(e). The selected methodology is used to establish interim fee-for-service rates before a public rate hearing, though the rates are subject to change with any subsequent rate hearings or with Average Wholesale Price changes. MCOs should continue to utilize the TMHP Fee Schedule for the most current information on reimbursement rates, which is located at the following URL: [tmhp.com/pages/topics/rates.aspx](http://tmhp.com/pages/topics/rates.aspx).





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Reasonable administrative costs associated with coverage of these drugs as well as any adjunctive therapies associated with the treatment of these drugs will be part of the existing Capitation Rate. The MCO may not include the cost of the drugs in the Financial Statistical Report. HHSC publishes a daily non-risk drug file to TxMedCentral, which lists all drugs that are designated as eligible for a non-risk payment. For each listed drug, the file contains the following information: the non-risk payment national drug code (NDC); the drug name; an indicator identifying whether the drug is on the formulary or is a clinician-administered drug; and the dates of eligibility for a non-risk payment. HHSC uploads the daily file to the TxMedCentral website, specifically placing the file within each MCO's "MCOPHARM" folder, under the file name, "CAD\_Formulary\_NRPjjjy."

Non-risk based coverage and pricing for Clinician Administered Drugs may change once per quarter. The daily file will reflect these changes no later than the 15th of the month for each coverage quarter (i.e. October, January, April, July).

## F. STAR+PLUS and STAR Kids Services for Dual Eligibles

When an authorization request for any LTSS service, including PCS, PDN, and CFC, is submitted to a STAR+PLUS or STAR Kids MCO for a Dual Eligible Member, the MCO must not require providers to submit a Medicare denial for services that are never covered or paid by Medicare. While an all-inclusive list of these services does not exist, the following website provides a list of some DME that Medicare covers: <http://www.medicare.gov/coverage/durable-medical-equipment-coverage.html>.

## G. Nursing Facility Add-on Services

Section G applies to all Nursing Facility Add-on Services provided to Nursing Facility residents with the exception of add-on therapy services, which are specified below in Section H.

MCOs may pay claims for Nursing Facility Add-on Services received from:

- (1) providers not affiliated with a Nursing Facility, or
- (2) the Nursing Facility that employs the provider providing the services as long as the facility and provider have the same tax identification number and National Provider Identifier (NPI).

To adjudicate claims received from providers other than Nursing Facilities or facility employees, the MCO must contract directly with the provider. The provider must be credentialed and bill the MCO directly for Nursing Facility Add-on Services. The MCO may deny claims submitted by a Nursing Facility on behalf of a provider who is not employed by the Nursing Facility.

The MCO may deny any claims for Nursing Facility Add-on Services that include Nursing Facility Unit Rates or Medicare Coinsurance as defined in UMCM, Chapter 2.3, "Nursing Facility Claims Manual." MCOs may direct providers to submit claims for add-on services separately from claims for the unit rate. Reporting requirements found in the MCO's Contracts and this and other chapters of the Uniform Managed Care Manual apply.



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## **H. Nursing Facility Add-on Therapy Services**

Nursing Facility add-on therapy services include occupational, speech, and physical therapy services not included in the Nursing Facility Unit Rate. MCOs may pay claims for Nursing Facility add-on therapy services received from:

- (1) providers not affiliated with a Nursing Facility, or
- (2) the Nursing Facility where the service was rendered.

The MCO may not deny claims for Nursing Facility add-on therapy services for the sole reason that the claim was submitted by a Nursing Facility on behalf of a provider who is not employed by the Nursing Facility.

The MCO may deny any claims for Nursing Facility add-on therapy services that include Nursing Facility Unit Rates or Medicare Coinsurance as defined in UMCM, Chapter 2.3, "Nursing Facility Claims Manual." MCOs may direct providers to submit claims for Nursing Facility Add-on Services separately from claims for the unit rate.

Reporting requirements found in the MCOs' Contracts and this and other Chapters of the Uniform Managed Care Manual apply.

## **I. Family Planning Services**

MCOs must reimburse long acting reversible contraception (LARC) devices in addition to the hospital payment for delivery services when insertion of a LARC device is performed immediately postpartum. "Immediately postpartum" refers to insertion of a LARC device within 10-15 minutes of placental delivery after vaginal or cesarean delivery for intrauterine devices (IUDs) or before discharge for implantable contraceptive capsules.

MCOs must reimburse LARC devices in addition to the Federally Qualified Health Center (FQHC) encounter payment. LARC devices are not subject to FQHC family planning encounter limitations, as outlined in Section 4, "Federally Qualified Health Center (FQHC)" of the Clinics and Other Outpatient Facility Services Handbook of TMPPM Volume 2, Provider Handbooks.

Additional information on add-on reimbursement for LARC devices is provided in the TMPPM.

This subsection does not apply to CHIP and CHIP Perinatal MCOs.

## **J. Human Donor Breast Milk**

MCOs must reimburse for human donor breast milk in the inpatient setting in addition to the hospital payment for delivery services, as well as reimbursing for human donor breast milk in the outpatient or home setting.

## **VIII. REMITTANCE AND STATUS REPORTS**

The MCO must include detailed information to allow the provider to easily identify the claim, such as: claim number, date of service, billed services, Member name, Member ID number, and reason code for the Remittance and Status Report or other remittance communication.



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## IX. PERFORMANCE REQUIREMENTS AND TIMEFRAMES

HHSC may impose contractual remedies, including liquidated damages if the MCO or its subcontracted claims processor does not process and finalize electronic and paper claims according to the following performance requirements and timeframes.

1. Within 30 Days of receipt, Adjudicate 98 percent of all Clean Claims by claim type and by Program.
2. Within 90 Days of receipt, Adjudicate 99 percent of all Clean Claims by claim type and by Program.
3. Within 30 Days of receipt, Adjudicate 98 percent of all Appealed Claims by claim type and by Program
4. The MCO and subcontracted claims processors are required to finalize all claims, including Appealed Claims, within 24 months from the date of service.

## X. INTEREST PAYMENTS

The MCO is subject to contractual remedies, including liquidated damages, if the MCO does not pay providers interest at an 18 percent annual rate, calculated daily, for the full period in which the Clean Claim, or portion of the Clean Claim remains un-adjudicated beyond the 30-Day Claims Processing deadline.

The principal amount on which the interest payment will be calculated is the amount due but unpaid at the contracted rate for the service.

The MCO must keep an accurate and sufficient audit trail for each interest payment and its corresponding claims documentation and provide a detailed report to HHSC upon request.

## XI. NINETY-FIVE-DAY PROVIDER CLAIM FILING DEADLINE

A provider must file a claim with the MCO or its subcontracted claims processor within 95 Days from the date of service. If a claim is not received by the MCO within 95 Days, the MCO must deny the claim unless excepted from the claims filing deadline, see below and the TMPPM Section 6.1.4, "Claims Filing Deadlines," which includes exceptions for inpatient facility claims, claims by newly-enrolled Medicaid providers, claims by out-of-state providers, and other exceptions.

When a claim for LTSS covers multiple dates of service (span billing), the 95-Day deadline is based on the first day of service in the date span. For example, if the claim covers dates of service January 1 through January 15, the 95-Day filing deadline begins on January 1. Span billing most commonly arises in claims for attendant care and adult day care services.

If the provider files with the wrong plan within the 95-Day submission requirement with the State claims administrator but not with the MCO and produces documentation to that effect, the MCO must honor the initial filing date and process the claim without denying the resubmission for the sole reason that the filing timeframe has passed. The provider must file



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the claim with the correct MCO within 95 Days of the date on the Remittance and Status Report from the other carrier.

When a service is billed to a third-party insurance resource other than the MCO, the claim must be refiled and received by the MCO within 95 Days from the date of disposition by the other insurance resource. The MCO will determine, as a part of its provider claims' filing requirements, the documentation required when a provider refiles these types of claims with the MCO.

## **XII. MCO FINANCIAL SETTLEMENTS WITH PROVIDERS**

There should be no need for special settlements except for advance draws by providers against future payments, unless agreed to by both the MCO and the provider by contract. The intent of this provision is to preclude MCOs from settling with providers for service rendered or for interest payments due to inaccurate or untimely processing of claims by the MCO or its Subcontracted Claims Processor.

The MCO should inform providers that the HHSC/MCO Contract allows for the resolution of disputes through binding arbitration or litigation according to the MCO's Provider contracts.

## **XIII. PROVIDER EDUCATION AND CLAIMS CODING/PROCESSING GUIDELINES**

The MCO establishes and applies its own claims filing requirements for its Providers. These requirements must be clearly set out in the MCO Provider Manual.

The MCO must make available to contracted Providers its claims coding and processing guidelines. The information furnished to the Providers should be specific to codes and processing guidelines for particular programs and providertypes.

The MCO must provide Providers written notice at least 90 Days prior to implementing any changes to these guidelines, unless changes mandated by HHSC require a shorter notice period.

The MCO's Provider services staff must train Provider claims staff on an individual and group basis at time intervals appropriate to each Provider.

## **XIV. INTERNAL CLAIMS AUDITING**

The MCO must maintain appropriate levels of claims auditing staff to quickly identify processing errors and trends. The MCO's claims audit procedures must comply with accepted industry practices, processes and standards.

The MCO must provide adequate training and supervision to audit staff and claim processors. The claims audit reports should be reviewed with MCO management to ensure that Claims Processing and management systems are adjusted as needed for continuous quality improvement. The claims auditing function should report to the highest level of claims operations, or to a higher executive management position.



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All MCO claims data, processing, performance, and functions are subject to audit by HHSC, HHSC's designated agent, or federal or state audit entities.

## **XV. HIPAA COMPLIANCE IN REMITTANCE FORMATS**

The MCO must comply with HIPAA EDI requirements in claims and remittance transactions in the 837/835 formats.

## **XVI. SUBCONTRACTOR CLAIMS PROCESSING**

A violation of the HHSC Claims Processing requirements by a Subcontractor or delegated entity will be a violation by the MCO. The MCO must ensure that each Subcontractor complies with all HHSC-required procedures, classifications, and claims systems requirements, including timely submission to the MCO of all HHSC required Claims Processing reports or data.

The MCO must notify HHSC of a Subcontractor's violation of the claims policies and procedures within 30 Days of identifying any violation. The MCO must provide any additional information relevant to the Subcontractor's violation upon HHSC's request. The MCO is responsible for preparing and implementing a corrective action plan and for monitoring the Subcontractor until the Subcontractor is fully in compliance with HHSC's Claims Processing and reporting requirements.

## **XVII. SYSTEM/SUBCONTRACTOR CHANGES**

The MCO must notify HHSC of major claims systems changes in writing no later than 180 Days prior to implementation. The MCO must provide an implementation plan and schedule of proposed changes at the time of this notification for HHSC's approval to ensure Claims Processing functions are not adversely impacted during the transition period.

The MCO must notify HHSC in writing no later than 180 Days prior to the MCO's intention to terminate a Subcontract with a claims processor or immediately upon receiving notification from the subcontracted claims processor of its intent to terminate any Subcontract. The MCO is required to provide an implementation plan and schedule of proposed changes at the time of this notification for HHSC's approval. The MCO may be required to submit additional information related to any change of Subcontractor.

## **XVIII. DATA RETENTION**

The MCO's claims system must maintain online and archived files. The MCO must keep an online automated claims payment history for the most current 18 months. STAR+PLUS MCOs must keep online automated Nursing Facility claims payment history for the most current 24 months.

The MCO must store archival data that is easily retrievable, for a minimum period of 10 years after the Contract Expiration Date or until the resolution of all litigation, claims, financial management reviews, or other state or federal reviews, investigations, or audits pertaining to the Contract, whichever is longer.



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If the MCO's claims system is upgraded or replaced, the MCO is required to ensure that all historical claims data are accurately converted and stored in the new or upgraded system after such changes in accordance with the record retention requirements.

## **XIX. REPORTING REQUIREMENTS**

See Uniform Managed Care Manual Chapter 5.24.1, "Claims Summary Report Text File Layout."